APPENDIX I: STATE LAWS AND REGULATIONS PROVIDING QUALITY AND GRIEVANCE PROTECTIONS

The statutes and regulations of the Commonwealth of Virginia that address quality of care in HMOs and other forms of managed care are presented here according to the seven components of quality adopted by the HB 2785 study group as an organizing principle for the study. These components are **complaint resolution; access and availability; prevention; credentialing; consumer eduction, awareness and satisfaction; outcome measures; and improvement of community health.** Under each of the components, the applicable laws are included according to whether they apply to HMOs only or to all health insurers. This section begins with laws that address quality in general. (There are no statutes or regulations that pertain specifically to improvement in community health within the context of managed care.)

1. Laws Addressing Quality of Care in General

a. HMOs Only

***Code of Virginia*, §32.1-122.10:01, Review of Health Maintenance Organizations**

"The State Health Commissioner shall examine the quality of health care services of any health maintenance organization licensed in Virginia... and the providers with whom the organization has contracts, agreements or other arrangements according to the HMO's health care plan as often as considered necessary for the protection of the interests of the people of this Commonwealth." This statute further provides that the Health Commissioner may "review records, take affidavits, and interview the officers and agents of the HMO and the principals of the providers concerning their business."

***Code of Virginia* §38.2-4316.4 , Suspension or Revocation of Licensure**

This section allows for suspension or revocation of an HMO's license if "[t]he State Health Commissioner certifies to the Commission that the health maintenance organization is unable to fulfill its obligations to furnish quality health care services as set forth in its health care plan consistent with prevailing medical care standards and practices in the Commonwealth..."

***Code of Virginia* §38.2-4301.B.11.,** and ***Virginia Administrative Code* , 14-5-210-50.n., Requirement that HMOs Have a Quality Program**

Neither the statutes nor the regulations contain explicit requirements for an HMO's Quality Assurance plan, structure, or functions. The only requirements for quality *per se* are at **14 VAC 5-210-50.n.**: "Each application [for licensure] for a health maintenance organization shall set forth or be accompanied by... [a] description of the procedures and programs established by the HMO to (i) assure both availability and accessibility of adequate personnel and facilities, and (ii)

assess the quality of health care services provided." This regulation is identical to Section **§38.2-4301.B.11.** of the *Code*.

b. All Health Insurers

There are no laws or regulations pertaining explicitly to quality for other forms of managed care. A quality program is not required and there are no provisions for examination of the quality of health services by the Health Commissioner.

2. Complaint Resolution and Consumer Satisfaction

a. HMOs Only

***Code of Virginia* §38.2-4308., HMOs required to have a complaint system**

This section requires that HMOs establish a complaint system for the resolution of written complaints. The complaint system must be approved by the State Health Commissioner and the Bureau of Insurance. This section also requires that HMOs submit to the Health Commissioner a copy of their annual complaint report. Both the State Corporation Commission (the Bureau of Insurance) and the State Health Commissioner are required to examine HMO complaint systems although the SCC may accept the Health Commissioner's report rather than conduct their own examination.

Virginia Administrative Code, 14-5-210-70.H., Grievance Procedure

This regulation expands on the *Code* requirement at 38.2-4308, stipulating that records of all complaints be maintained for three years and requiring that HMOs provide complaint forms and/or written procedures to enrollees. Grievances are required to be resolved in not more than 180 days. This regulation also prohibits termination of a member's coverage for any reason related to the grievance and makes provisions that apply in the event of specific arbitration agreements.

***Code of Virginia,* §38.2-4318, Suspension or Revocation of Licensure**

This section expressly provides for loss of licensure if the HMO fails to implement a complaint system in accordance with 38.2-4308.

b. All Health Insurers

***Code of Virginia,* §38.2-511, Requiring Records of Complaints**

There are no statutes or regulations requiring that health insurers other than HMOs have

grievance systems or procedures. The Code section cited above requires all insurance companies to maintain complete records of all complaints since the last market conduct examination or for the last three years, whichever is the more recent time period. This section also defines a "complaint" as any written communication expressing a grievance.

***Code of Virginia*, Chapter 54 of Title 38.2, Appeals of Utilization Review Decisions**

Chapter 54 applies to all health insurers that perform utilization review (UR), the determination of whether covered services are medically necessary. Chapter 54 provides for appeals of UR decisions, and thus addresses one of the most important aspects of consumer protections in managed care. Chapter 54 contains the following provisions:

> Health Insurers are required to establish standards and criteria to be applied in UR decisions. These standards are required to be reviewed by appropriate board-certified physicians; to be compatible with "established principles of health care," and sufficiently flexible to permit needed exceptions. This section also requires the insurer to make available to providers, on written request, the UR standards and criteria and the list of physician advisors and their areas of specialty. (§38.2-5402.A)
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> UR staff are required to be properly qualified and supported by a physician advisor, and a representative who is authorized to approve UR decisions must be available to providers and covered persons. (§38.2-5402.E)
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> Health Insurers are required to notify covered persons of the review process, and to also notify providers upon written request. (§38.2-5402.F)
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> Health Insurers are required to communicate UR decisions no later than two business days after receipt of all necessary information.(§38.2-5402.G)
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> Health Insurers are required to have a utilization review plan that contains procedures for compliance with Chapter 54. The plan must contain specific procedures to be used in UR determinations; provisions for advance notice to enrollees of any requirements for pre-authorization of services; and provisions for reconsiderations and appeals of UR decisions. This section requires the insurer to make available to providers and enrollees, on written request, a copy of those portions of the UR plan that are relevant to the specific request. (§38.2-5403)
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> The first denial by the insurer of a covered service is called an adverse decision and must be communicated to the treating provider within two business days. The provider must be notified at this time of the instructions for requesting a reconsideration of the adverse decision. (§38.2-5406) If the reconsideration is to again deny coverage for the service, it is called a final adverse decision and must include the criteria used and the clinical reason

for the adverse decision as well as alternate treatments. Reconsiderations must be completed within ten business days, and providers must be notified of the opportunity for an appeal of the final adverse decision. (§38.2-5407)

Every health insurer is required to have a process for appeals of final adverse decisions that are appealed by covered persons, their representative, or their provider. Response to appeals must be provided to appellants no later than sixty business days after the insurer has received all required documentation. The appellant may request that the decision on the appeal be in writing and all decisions must state the criteria used and the clinical reason for the decision. (§38.2-5408.A.)

Reconsiderations and appeals must be reviewed by a provider advisor or advisors, at least one of whom is a peer of the treating health care provider. The peer provider must be specialized in the same or similar discipline as the treating health care provider, and, if a physician, must be board certified or board eligible. The peer provider may not have participated in any previous decisions regarding the case under appeal; must not be employed by or a director of the insurance company, and must be licensed to practice in Virginia or a state with comparable licensing laws. (§38.2-5408.B.)

Appeals of adverse decisions or adverse reconsiderations may be made on an expedited basis if the time limits for regular reconsiderations and appeals would create a delay that would be detrimental to the health of the covered person. (§38.2-5408.E.2.) The requirements for peer review at §38.2-5408.B. do not pertain to expedited decisions.

Health insurers are prohibited from terminating provider contracts or penalizing providers for advocating for patients in the appeals process unless the provider "engages in a pattern of filing appeals that are without merit." (§38.2-5408.G.)

All insurers subject to Chapter 54 are required to maintain in writing records of review procedures; qualifications of UR staff; UR criteria; all appeals and the manner in which they were resolved; the number, type and outcome of adverse decisions and appeals; expedited appeals; and procedures for ensuring confidentiality of medical records. Records must be maintained for a period of five years, and all records are subject to examination by the State Corporation Commission. (§38.2-5409)

3. Access and Availability

a. HMOs Only

***Code of Virginia,* §38.2-4301.4**
***Virginia Administrative Code,* 14 VAC-5-210-50.B.3.e.**
***Virginia Administrative Code,* 14 VAC-5-210-110.C.**
This statute and these regulations require an HMO to file with the Bureau of Insurance either every contract they have with a provider, or every type of contract and a list of providers in their networks. This is a condition for licensure and enables the Bureau to assess the accessibility, and to some degree, the adequacy of the network. The *Code* further requires that the list of providers with whom the HMO has contracts be updated quarterly and filed with the Bureau. (§38.2-4311)

***Virginia Administrative Code,* 14 VAC-5-210-90.A., Access to Care**

This regulation provides the following standards for access to care:

1. Each health maintenance organization shall establish and maintain adequate arrangements to assure both availability and accessibility of adequate personnel and facilities providing health care services including:

a. Reasonable hours of operation and after-hours emergency health care;

b. Reasonable proximity to enrollees within the service area so as not to result in unreasonable barriers to accessibility;

c. Sufficient personnel, including health professionals, administrators, and support staff, to reasonably assure that all services contracted for will be accessible to enrollees on an appropriate basis without delays detrimental to the health of enrollees; and

d. Adequate arrangements to provide inpatient hospital services for basic health care.

2. Each health maintenance organization shall make available to each enrollee the services of specialists as part of the provision of basic health care services. ”

***Code of Virginia,* §38.2-4300, Definition of Emergency Services**:

This section defines emergency services as care sought in response to the sudden onset of symptoms of sufficient severity that a prudent layperson could reasonably expect to result in serious impairment to physical or mental health. This definition is an important protection for HMO members because it defines an emergency on a prospective basis from the consumer’s viewpoint rather than on a retrospective basis from the HMO’s viewpoint.

***Code of Virginia,* §38.2-4312.3.A., Patient Access to Emergency Services**

This section requires HMOs to provide 24-hour access to medical care or by telephone to a licensed health care professional who can refer an HMO member to appropriate care.

***Code of Virginia,* §38.2-4312.3.B.**, **Reimbursement for Emergency Services**
This section reinforces the previous provisions for emergency care with the requirement that an HMO cover any emergency services for which the patient was referred by a physician or other person acting as an agent for the HMO. It also requires HMOs to cover any emergency room payment if the HMO fails to have a system for provision of twenty-four-hour access.

***Code of Virginia,* §38.2-4312.1**, **Pharmacies; Freedom of Choice**

This section permits an HMO enrollee to select any out-of -network pharmacy from which to receive pharmacy benefits as long as the pharmacy has notified the HMO in advance that it will accept reimbursement commensurate with the HMO's contracted rate.

b. All Health Insurers

***Code of Virginia,* §38.2-3407.10.J and K, Contracts may not prohibit discussion of treatment options, contracts must require discussion of treatment options**

This section of the code requires any insurers contracting with providers to ensure that provider contracts do not prohibit the provider from discussion of treatment options with patients. Section K requires that contracts "permit and require the provider to discuss medical treatment options with the patient."

***Code of Virginia,* §38.2-3407.10.C., and §38.2-3407.10.F.1. Continuity of Care**

This first section of the *Code* provides for notification to enrollees when their primary care provider's contract is terminated by an insurance carrier and establishes the right of an enrollee to continue receiving services for sixty days from the date of the primary care physician's notice of termination. 38.2-3407.10.10.F.1. provides for continuity of care for at least sixty days with any contracted provider from the date of notice of termination when the patient has been in an active course of treatment with the provider and desires to continue treatment.

***Code of Virginia,* §38.2-3407.11, Access to Obstetricians and Gynecologists**

§38.2-3407.11 permits covered females thirteen and older to self-refer directly to Obstetrician/Gynecologists without a referral or authorization from the primary care physician or the insurance plan. This section requires that the insurer notify its subscribers of this provision.

***Code of Virginia,* §38.2-3414.1, Maternity Length of Stay**

Mandates post-partum services in accordance with specific guidelines of the American Academy of Obstetricians and Gynecologists and the American Academy of Pediatrics. This section ensures an appropriate length of stay in the hospital following delivery and provides for home health services following a stay shorter than 48 hours for a normal delivery or 96 hours for a Caesarean Section delivery.

***Code of Virginia,* 38.2-3407.7, Pharmacies, Freedom of Choice**

This section permits enrollees to select any pharmacy to provide covered pharmacy benefits whether or not the pharmacy is contracted by the insurance plan, and makes provisions for non-contracted pharmacies.

***Code of Virginia,* 38.2-3407.6, Inclusion of Podiatrists**

Health Insurers are prohibited from excluding podiatrists solely for the reason that the insurer requires contracted providers to have hospital privileges as long as the podiatrist is able to perform the type of services that are covered by the insurance plan.

***Code of Virginia,* 38.2-3407, Any Willing Provider**
(APPLIES TO PPO'S ONLY)

This section requires Preferred Provider Organizations (PPO) to include in their provider networks any hospital, physician or type of provider listed in §38.2-3408 willing to meet the terms and conditions offered by the PPO.

4. Prevention

a. HMOs only

***Code of Virginia,* §38.2-4300, definition of health care services for HMOs**
***Virginia Administrative Code,* 14 VAC 5-210-90, HMO Services**

§38.2-4300 defines "basic health care services" provided by HMOs to include "preventive health services". The regulation at **14 VAC 5-210-90.B.** specifies the minimum basic health services HMOs are obligated to provide and includes "[p]reventive health services: services provided with the goal of protection against and early detection and minimization of the ill effects and causes of disease or disability, including well-child care from birth, eye and ear examinations for children age 17 and under to determine the need for vision and hearing correction, periodic health evaluations, and immunizations..."

b. All Health Insurers

***Code of Virginia,* §38.2-3411.1, Coverage for Child Health Supervision Services**
***Code of Virginia,* §38.2-3418.1, Coverage for Mammograms**
***Code of Virginia,* §38.2-3418.1:2, Coverage for Pap Smears**
***Virginia Administrative Code,* 14 VAC 5-234-50, Essential Benefits Plan**

These sections of the Code require insurers, health services plans and health maintenance organizations to cover child health supervision services, mammograms, and pap smears. The regulation cited mandates that insurers offering Essential Benefit Plan contracts cover preventive care for children "consistent with the current recommendations of the American Academy of Pediatrics and for adults according to the recommendations of the American Academy of Family Physicians."

5. Credentialing

a. HMOs Only

***Code of Virginia,* §38.2-4300, Definition of HMO Provider**

Nothing in the insurance title of the Code of Virginia or in administrative law requires that HMOs examine the credentials of providers with whom they contract. HMOs are only required to contract with licensed providers as indicated in the definitions section at §38.2-4300 which defines provider as "any physician, hospital, or other person that is licensed or otherwise authorized in the Commonwealth to furnish health care services."

b. All Health Insurers

***Code of Virginia,* 54.1-2902, unlawful to practice medicine without a license**

This section of the Code makes it unlawful to practice medicine, osteopathic medicine, chiropractic, podiatry, physical therapy, clinical therapy etc. without a valid unrevoked license issued by the Board of Medicine.

***Code of Virginia,* 32.1-123 et seq., licensure of facilities**

These sections of the Code set out the requirements for licensure of facilities, including hospitals, nursing homes and home health agencies.

***Code of Virginia,* 32.1-134.1 through 32.1-134.4, hospital credentialing of providers**

This section of the Code addresses procedures and standards that hospitals must follow in granting staff membership or clinical privileges to providers.

***Code of Virginia,* 54.1-2906, mandate to report disciplinary actions against providers**

Sec. 54.1-2906 requires hospitals "and other health care institutions" to report disciplinary actions against health professionals to the Board of Health Professions; however, health maintenance organizations and other insurers are not included in the definition of health care institutions. Sec. 54.1-2906.B. requires the State Health Commissioner also to report to the appropriate board information of fraud or unethical or unprofessional conduct by a practitioner.

The Commonwealth's current authority for credentialing of providers rests with the requirements for licensure and renewal assumed by the Board of Health Professions and the Department of Health. This authority pertains to individual practitioners and facilities, not insurers.

6. Consumer/Provider Education and Awareness

a. HMOs Only

Obligations of the Insurer for disclosure are an important consumer protection. The following statutes and regulations require HMOs to disclose particular information to the consumer:

***Code of Virginia,* 38.2-4306, Evidence of Coverage notification requirements**

The Evidence of Coverage (EOC) is the insured's contract or agreement with an insurance company "issued to a subscriber setting out the coverage and other rights to which an enrollee is entitled" (**Code, 38.2-4300,** definitions). **38.2-4306** requires that HMOs disclose to the consumer the following:

1. All health care services and benefits to which the enrollee is entitled

2. Any limitations on services and benefits, including copayments and deductibles

3. Where and how to receive information as to how services may be obtained

4. The total amount of out-of-pocket expenses the enrollee is obligated to pay

5. A description of the HMO's method for resolving enrollee complaints

6. A list of providers and a description of the service area, if such information is not given to the enrollee at the time of enrollment

7. The right of group contract enrollees to convert their coverage to an individual contract

The *Code* (**38.2-4312.3.C**). additionally requires that the EOC include a description of procedures to be followed in an emergency and the member's potential financial responsibility of payment for non-emergency services rendered in a hospital emergency room.

***Virginia Administrative Code*, 14 VAC 5-210-100, Disclosure Requirements**

The disclosure requirements necessary in the EOC are listed in this regulation and contain the same provisions as those in the *Code* at 38.2-4306 in virtually identical language. This regulation additionally contains requirements for disclosure of the terms of coverage and termination; provisions for coordination of benefits, assignment restrictions, and eligibility requirements; procedures for filing claims; and premium grace periods.

***Code of Virginia*, 38.2-4306.e.; 14 VAC-5-210-70.H.2, Disclosure of Grievance Procedures**

HMOs are required to disclose the enrollee grievance procedure in the Evidence of Coverage **(38.2-4306.e**). The regulation cited requires the HMO to provide complaint forms and/or written procedures to enrollees who wish to file a written complaint. The information provided must include appropriate telephone numbers and addresses as well as time frames for grievances.

***Virginia Administrative Code*, 14VAC-5-210-70.D. and E., Description of Providers Annually or upon Request; Service Area Disclosure**

These regulations require that HMOs notify subscribers at the time of enrollment or the issuance of the EOC the names of all network providers and the HMO's service area. This information must also be available on written request of the enrollee or at least annually.

***Virginia Administrative Code*, 14 VAC-5-210-70-C., Notification of Maximum Copayment Amount**

This regulation requires an HMO to disclose the maximum copayment amount in the enrollee's EOC. Another provision requires the HMO to keep accurate records of each enrollee's copayment expenses and to notify the enrollee when the maximum is reached.

***Virginia Administrative Code*, 14 VAC-5-210-70.G., Freedom of Choice of Physician**
***Code of Virginia*, 38.2-4304.B.; *Virginia Administrative Code*, 14 VAC 5-210-50.B.3.o., Consumer Involvement Required**

Other statutes and regulations addressing consumer satisfaction for HMO enrollees include:

***Virginia Administrative Code*, 14 VAC-5-210-70.G.** which requires that an HMO allow an enrollee the right to select a primary care physician (PCP), subject to availability, and to change PCP's.

***Code of Virginia*, 38.2-4304.B.** requires the governing bodies of HMOs to establish a mechanism to provide enrollees with the opportunity to participate in "matters of policy and operation," either through the establishment of advisory panels, advisory referenda on major policy decisions, or some other mechanism. The associated regulation at **14 VAC-5-210-50.B.3.o.** requires as a condition for licensure a description of how the HMO will implement 38.2-4304.B. of the *Code*.

b. All Health Insurers

Disclosure requirements for other forms of health insurance are fewer than those for HMOs, as follows:

***Code of Virginia*, §38.2-305; Disclosure of Bureau of Insurance Toll-Free Number for Assistance**

This section requires all insurers to disclose in their contracts or policies information on how to contact the Bureau if they are unable to obtain satisfaction from their insurance company or agent. HMOs are additionally required to add the statement: "We recommend that you familiarize yourself with our grievance procedure, and make use of it before taking any other action." This section also requires disclosure of particulars of the insurance policy including premium, specific risks the subscriber is insured against, and the conditions pertaining to the insurance.

***Code of Virginia*, §38.2-5402.F Notification of review process**

All insurers that engage in utilization review (UR) activities are required to notify covered persons of the review process.

***Code of Virginia, §*38.2-3407.10.G.1., list of providers and who's not accepting new patients**

This section requires that any health insurance plan that establishes a panel of providers must notify purchasers at least annually of the list of providers on the panel and include an indication

of providers not currently accepting new patients.

***Code of Virginia*, §38.2-3407.4. Notification to purchaser of plan of incentives**

Health insurers are required to provide purchasers with a description of all types of payment arrangements used to compensate providers including risk-based payment and incentives to control utilization of services.

7. Outcome Measures and Accountability

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a. HMOs Only

There are no mandated outcome measures required of HMOs only.

b. All Health Insurers

***Code of Virginia*, §32.1-276.2 et seq**.

This section of the code specifically addresses outcome information by providing for the State Health Commissioner to contract with a non-profit organization to compile, store, analyze, and evaluate data submitted by health care providers. The definitions section, **32.1-276.3** defines "provider" to include "any person licensed to furnish health care policies or plans..." and so would include all health insurance carriers. **32.1-276.4** requires the Board of the non-profit entity to disseminate health care cost and quality information designed to assist consumers in purchasing health care services, including HEDIS information or reports voluntarily submitted by HMOs. (HEDIS is the acronym for Health Employer Data and Information Set, a set of outcome measures developed by the National Committee for Quality Assurance.) This section also requires that the non-profit organization submit to its Board, the General Assembly, and the Governor a strategic plan recommending specific data projects to be undertaken. Section 32.1-276.5 requires that "every health care provider submit data as required pursuant to regulations of the Board". It is important to note that at this time, it is not possible to include a payor identifier that identifies specific HMOs or other types of plans.